

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

14105

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed in pencil, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

14133			
1. PLACE OF DEATH a. COUNTY Queen Anne's		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Georgia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Queenstown		b. COUNTY Macon	
c. LENGTH OF STAY IN lb 0		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Macon	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS Rt + 1 49X-3	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Hilda	Middle Mae	Last Beckham
4. DATE OF DEATH	Month Dec.	Day 24	Year 1959
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 20, 1908
9. AGE (In years last birthday) 59 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	11. KIND OF BUSINESS OR INDUSTRY	12. BIRTHPLACE (State or foreign country) Georgia
13. FATHER'S NAME John C. Powell	14. MOTHER'S MAIDEN NAME Bessie Bullock	15. WAS DECEASED EVER IN U. S. ARMED FORCES? No	
16. SOCIAL SECURITY NO. —		17. INFORMANT Mr. Beckham	Address Rt + 1, Macon, Ga.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 816x		Cerebral Damage	
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		Fractured Skull	
DUE TO		Automobile Accident	
(c)		20 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Automobile Accident	
20c. TIME OF INJURY Month, Day, Year Hour p.m. 12/24/59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street Queenstown, Q.A., Md.
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Irvin G. Hoyt		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Irvin G. Hoyt		DATE SIGNED 12/24/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/28/59	22c. NAME OF CEMETERY OR CREMATORIUM Riverside Cemetery
22d. LOCATION (City, town, or county) MACON		(State) GA.	
23. FUNERAL DIRECTOR'S SIGNATURE Edna L. Lane		24a. ADDRESS Church Hill, MD.	24b. REC'D BY REGISTRAR DEG 29 '59
24c. REGISTRAR'S SIGNATURE Arthur S. Thrane			

HTA20 TO ESTABLISH A STABLE LINE OF HUMAN TUMOR CELLS.

卷之三

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

14106

14134

1. PLACE OF DEATH a. COUNTY QUEEN ANNE		MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY QUEEN ANNE
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GRASONVILLE		c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GRASONVILLE		d. STREET ADDRESS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First WILLIAM	Middle IRVIN	Last BURNS	4. DATE OF DEATH DECEMBER 8 1959	Month Day Year	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 9 - 1913	9. AGE (in years last birthday) 46 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATERMAN		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME JAMES E. BURNS		14. MOTHER'S MAIDEN NAME ELVIRA HORNEY				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT MRS. MARY BURNS = GRASONVILLE		Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. acute coronary occlusion (died in boat)		Dec. 8, 1959
(b) arteriosclerotic heart disease		several
(c) general arteriosclerosis / cerebral		years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) cerebral thrombosis middle cerebral artery Jan. 20, 57		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 19)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Stevensville	20f. (City or town) Stevensville	(County) Stevensville	(State) Md.

21. I certify that I attended the deceased from Jan. 17 , 1957 to Dec 8 , 1959, that I last saw the deceased alive on Dec 7 , 1959, and that death occurred at 8:55 A.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE Theodor Sattelmayer	ADDRESS (Street, city or town, state) Stevensville Md.		DATE SIGNED Dec. 9, 1959		

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF DEC. 10	22c. NAME OF CEMETERY OR CREMATORIAL STEVENSVILLE	22d. LOCATION (City, town, or county) STEVENSVILLE MD
23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lane Church Hill Md.	ADDRESS	24a. REC'D BY REGISTRAR DATE DEC 14 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 filmG234 1-18-60 et

14107

14135

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Queen Anne		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Queen Anne			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crumpton.		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crumpton		d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First BENJAMIN	Middle L.	Last GRAHAM	4. DATE OF DEATH December 9, 1959	Month December	Day 9	Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH March 16, 1880	9. AGE (In years last birthday) yrs. 78	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Phillip Graham			14. MOTHER'S MAIDEN NAME Anna Harmon						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Ella Graham,	Address Crumpton, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 2 hours.						
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Arteriosclerosis			DUE TO Arteriosclerosis						
DUE TO Arteriosclerosis			DUE TO Arteriosclerosis						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. p.m. 19	Month, Day, Year Dec. 9, 1959	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) MILLINGTON, MD	(County) MONTGOMERY	(State) MARYLAND			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on Dec. 9, 1959 , and that death occurred at 10:30 P.M. from the causes and on the date stated above.								ADDRESS (Street, city or town, state) MILLINGTON, MD	
ACTUAL SIGNATURE DR. GÉZA KORALEWSKI	DATE SIGNED 12-10-59								
PHYSICIAN'S NAME (Type) DR. GÉZA KORALEWSKI									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 12, 1959	22c. NAME OF CEMETERY OR CREMATORIUM Crumpton Cemetery	22d. LOCATION (City, town, or county) Crumpton	(State) MARYLAND					
23. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows, Millington Md.		ADDRESS Edward Fellows, Millington Md.	24a. REC'D BY REGISTRAR DATE DEC 14 '59	24b. REGISTRAR'S SIGNATURE George L. Russ					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

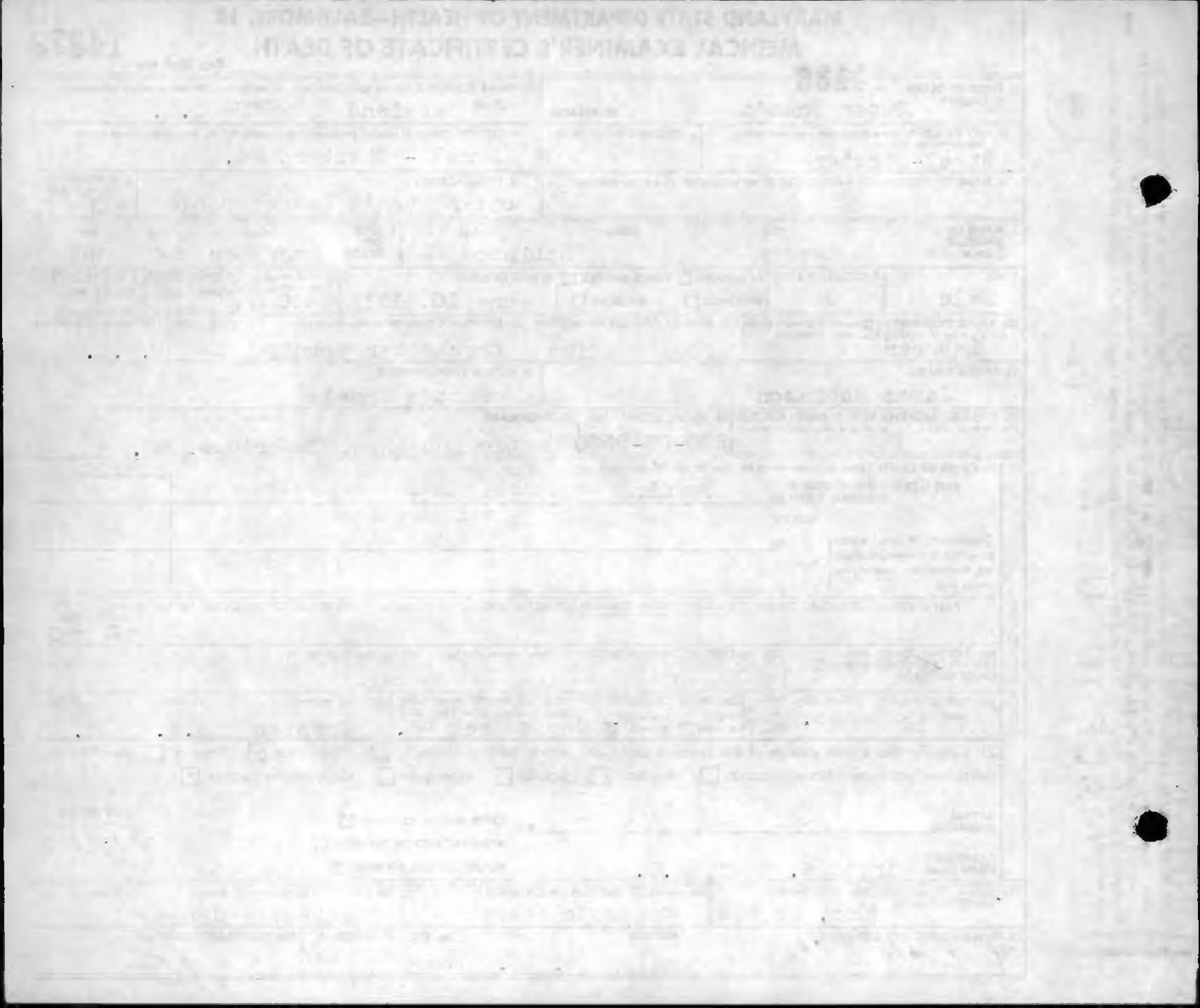
Item 18 Film 254 1-22-60 a.m.s

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

14372

1. PLACE OF DEATH a. COUNTY Queen Anne's		14135		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Q.A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Chester		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Rural - Chester, Md.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS Oscar Dunn's Oyster House		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Henson	Middle Robinson	Last	4. DATE OF DEATH	Month December	Day 24	Year 1959
5. SEX Male	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (in years from birthday) June 10, 1919	10. IF UNDER 1 YEAR Months 40 yrs.	11. IF UNDER 24 HRS. Days	12. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Food Packing		11. BIRTHPLACE (State or foreign country) Dorchester County		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Robinson				14. MOTHER'S MAIDEN NAME Mattie Ennals			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.		17. INFORMANT 220-03-9506 Mattie Robinson, Cambridge, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Penduline</i> Multiple contusions, fractures and abrasions DUE TO 812X Conditions, if any, which gave rise to immediate cause (a) (b) DUE TO cause last. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Man was found dead on road with external injuries. Presumed to have been hit by car.					
20c. TIME OF INJURY Hour p.m. Dec. 24 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Cox's Neck Rd.		20f. (City or town) Chester (County) Q.A. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input checked="" type="checkbox"/> .							
ACTUAL SIGNATURE <i>Irvin G. Hoyt</i>		DATE SIGNED 12/31/59					
EXAMINER'S NAME (Type) Irvin G. Hoyt, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL CREMATION, REMOVAL (Specify) Dec. 29, '59		22b. DATE THEREOF Dec. 29, '59		22c. NAME OF CEMETERY OR CREMATORIUM Crabo Cemetery		22d. LOCATION (City, town, or county) Dorchester County	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Herbert M. Wallace</i>		ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR DATE JAN 7 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus JAN 7 '60	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14198

14137

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Queen Anne's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Queen Anne's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stevensville	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stevensville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First William	Middle Richard	Last Roe
4. DATE OF DEATH	Month December	Day 23	Year 1959
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Aug 9-1903 56
9. AGE (In years last birthday) yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waiter	11. KIND OF BUSINESS OR INDUSTRY buying oysters	12. BIRTHPLACE (State or foreign country) Delaware
13. FATHER'S NAME John A. Roe	14. MOTHER'S MAIDEN NAME Mary A. Hess	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Address	
16. SOCIAL SECURITY NO.		17. INFORMANT James Roe - Stevensville	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH Dec. 23 1959	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 acute coronary occlusion, found dead in bed. Coroner called, inquest not necessary		DUE TO (b) Hypertensive cardio-vascular disease about 3 years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) arteriosclerosis general + cerebral about 3 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) chronic alcoholism + malnutrition severe months	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 18, 1956, to Dec. 23, 1959, that I last saw the deceased alive on December 22, 1959, and that death occurred at 12:15 P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) STEVENSVILLE, MD. DATE SIGNED 12/23/59	
ACTUAL SIGNATURE Theodor Sattelmaier	M.D.	PHYSICIAN'S NAME (Type) Theodor SATTELMAIER STEVENSVILLE MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 27	22c. NAME OF CEMETERY OR CREMATORIY Stevensville	22d. LOCATION (City, town, or county) Stevensville
23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lane Church Hill Md.	ADDRESS	24a. REC'D BY REGISTRAR DATE DEC 29 '59	24b. REGISTRAR'S SIGNATURE Oliver S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BY DIRECTIVE OF THE STATE DEPARTMENT

CLASSIFIED TO STATE

TOP SECRET

100-2000

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	1000
---	---	---	---	---	---	---	---	---	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	------

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1B

14138 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 14138

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the same, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

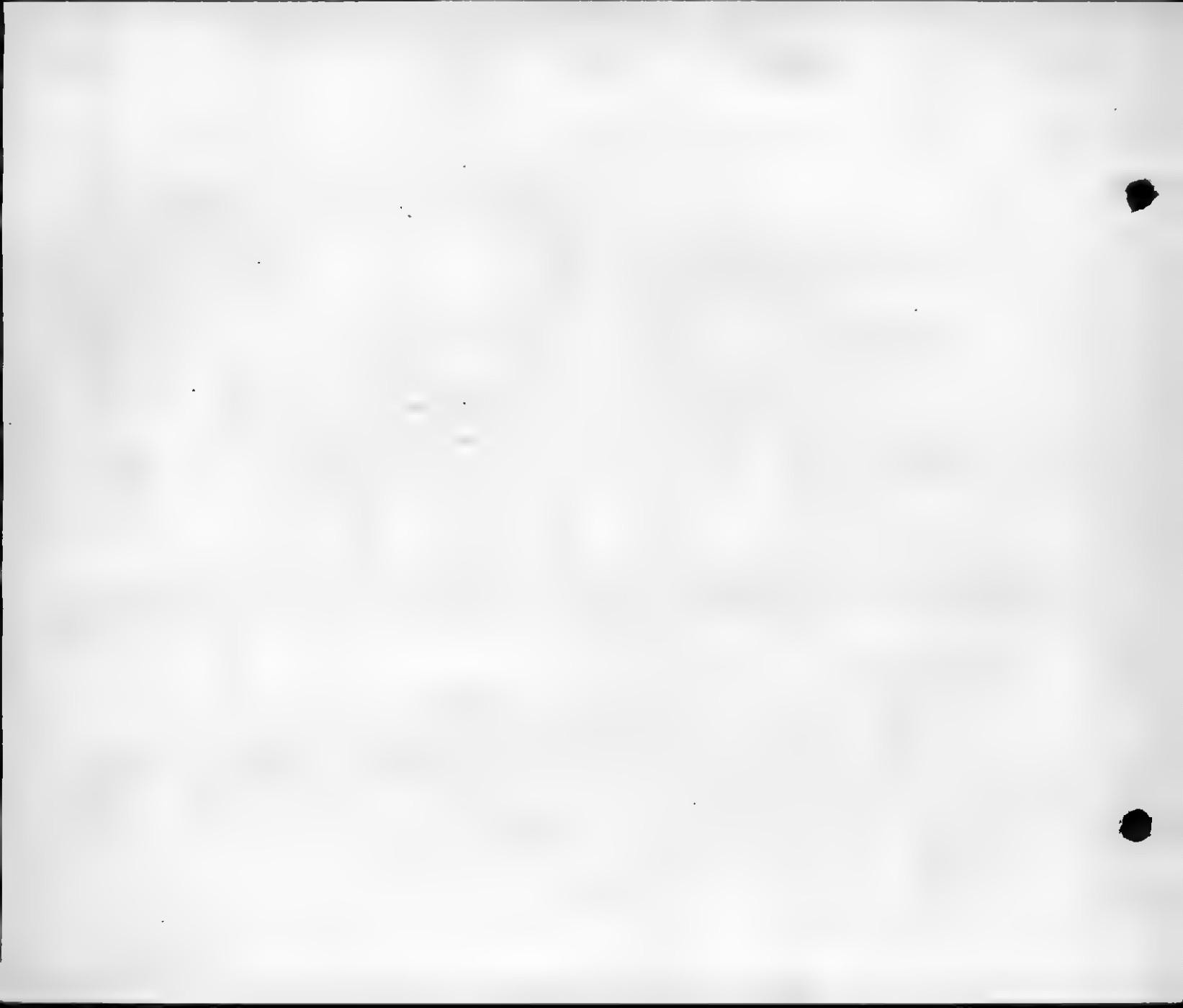
1. PLACE OF DEATH a. COUNTY <i>Queen Anne</i>	MARYLAND	2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Baltimore</i>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Marlins Farms</i>	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville 28</i>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>St. Mary's Rd.</i>	e. STREET ADDRESS <i>209 Shady Neck Court</i>	f. S. RESIDENCE ON FARM? <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <i>William J. Ryan</i>	First <i>W</i> Middle <i>I</i> Last <i>an</i>	4. DATE OF DEATH <i>Dec. 26 1959</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <i>1/21/01</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laundry man ret.</i>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Md.</i>
13. FATHER'S NAME <i>Wm. J. Ryan Jr.</i>	14. MOTHER'S MAIDEN NAME <i>Annie M. Wright</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>216 09 4521</i>	17. INFORMANT <i>Mrs Elizabeth Ryan</i> Address _____
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>332X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
19					

21. I certify that I took charge of the remains described above, held on Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes Accident , Suicide , Homicide , Undetermined manner

ACTUAL SIGNATURE <i>Irvin G. Hoyt</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED <i>12/26/59</i>		
EXAMINER'S NAME (Type) <i>Queens Town Md.</i>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12/29/59</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Towson Park</i>	22d. LOCATION (City, town, or county) <i>Baltimore Md.</i>	(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. MacNabb & Son</i>	ADDRESS <i>Catonsville 28 Md.</i>	24a. REC'D BY REGISTRAR <i>DEC 29 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Knoll</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

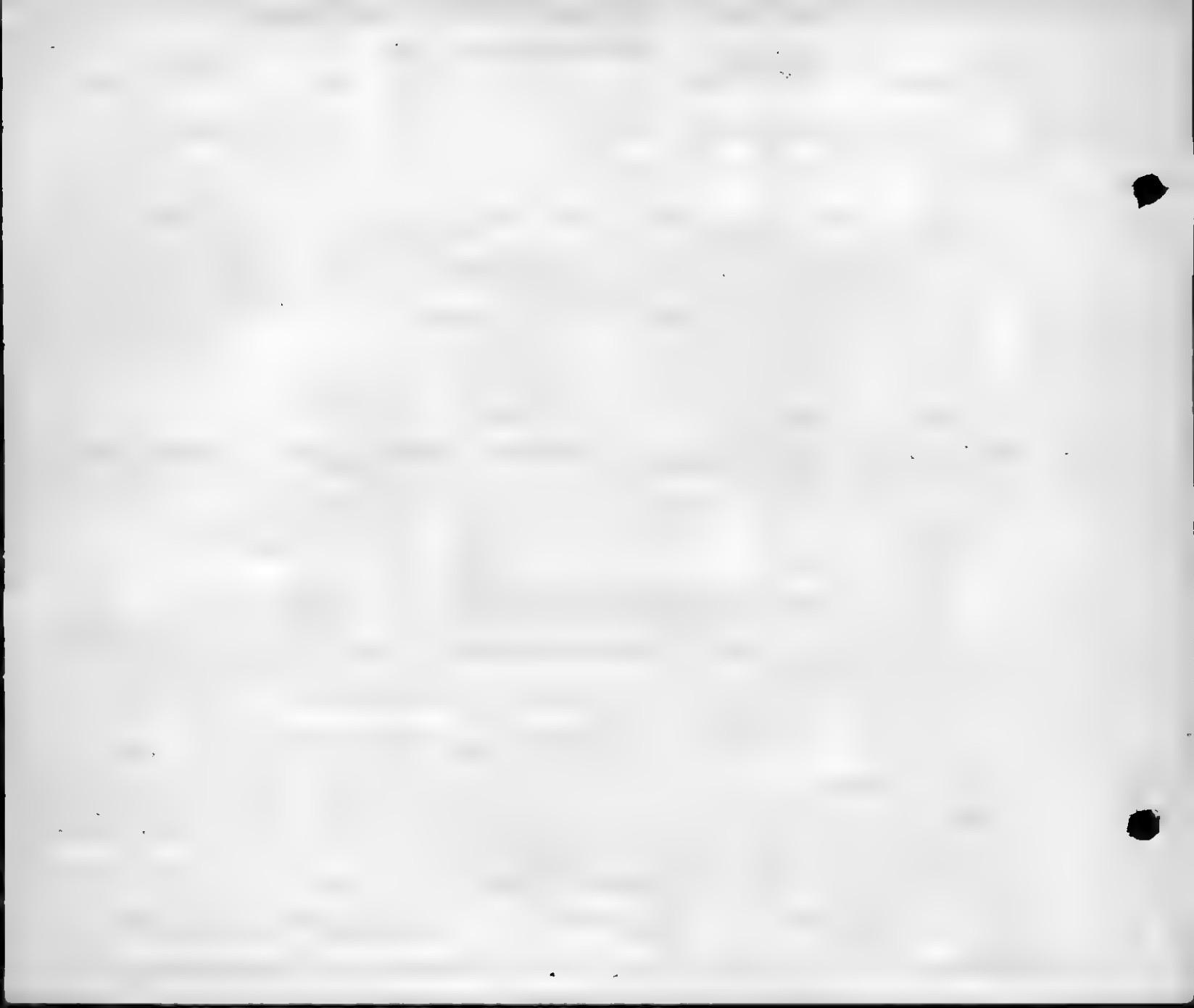
14139

CERTIFICATE OF DEATH

Reg. Dist. No.

14139

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE	
<i>Queen Anne's Maryland</i>		Md. Q. A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Centreville - Rural</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Centreville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —		e. STREET ADDRESS —	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Bordley</i>	Middle <i>Smallwood</i>	Last 4. DATE OF DEATH Month Day Year Dec. 23 1959
5. SEX <i>Male</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH ? ? 1889
9. AGE (In years last birthday) 70 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>	11. KIND OF BUSINESS OR INDUSTRY <i>Lumber</i>	12. BIRTHPLACE (State or foreign country) Md.
13. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	14. FATHER'S NAME <i>Unknown</i>	15. MOTHER'S MAIDEN NAME <i>Unknown</i>	16. SOCIAL SECURITY NO <i>218-20-3417</i>
17. INFORMANT <i>Lillian Hawkins</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>47.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Arteriosclerotic Heart Disease</i> ? yrs.	19. INTERVAL BETWEEN ONSET AND DEATH 0	
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	20c. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. ACTUAL SIGNATURE <i>Irvin G. Hoyt MD</i>	21. I certify that I attended the deceased from Oct. 1955 to Dec. 1959 that I last saw the deceased alive on Dec. 12, 1959, and that death occurred at 10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Queenstown, Md.</i>	DATE SIGNED <i>12/23/59</i>	
22a. PHYSICIAN'S NAME (Type) 22b. BURIAL, CREMATON, REMOVAL (Specify) <i>Burial Dec 26-1959</i>	22c. DATE THEREOF <i>Dec 26-1959</i>	22d. NAME OF CEMETERY, OR CREMATORIUM <i>Brunswick</i>	22e. LOCATION (City, town, or county) (State) <i>Rural Centreville, Queen Anne's County</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Elvorus Burton of Burton Bros</i>	24a. ADDRESS <i>Centreville Queen Anne's County</i>	24b. REC'D BY REGISTRAR DATE <i>12/25/59</i>	24b. REGISTRAR'S SIGNATURE <i>Elvorus Burton</i>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14140

CERTIFICATE OF DEATH

Reg. Dist. No.

14111

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)		
Queen Anne's MARYLAND		a. STATE Md. b. COUNTY Q. A.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Centreville</u>	c. LENGTH OF STAY IN lb <u>1yr.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Centreville</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Gary</u> Middle <u>Thomas</u> Last <u>Swann</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>10</u> Year <u>1959</u>		
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	7. B. DATE OF BIRTH <u>Jan. 28, 1958</u>	
WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. AGE (In years lost birthday) <u>1 yrs.</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Thomas Swann</u>		14. MOTHER'S MAIDEN NAME <u>Loris Stevens</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		
17. INFORMANT <u>Thomas Swann</u>		Address <u>Centreville</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>053.4</u> DUE TO <u>Bacteremia</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 hrs.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u>
21. I certify that I attended the deceased from <u>Dec. 9, 1959</u> , to <u>Dec 10, 1959</u> , that I last saw the deceased alive on <u>Dec 9, 1959</u> , and that death occurred at <u>5:45 A.M.</u> from the causes and on the date stated above.				ACTUAL SIGNATURE <u>Irvin G. Hoyt</u> M.D. ADDRESS (Street, city or town, state) <u>Queenstown, Md.</u> DATE SIGNED <u>14/10/59</u>
PHYSICIAN'S NAME (Type) <u>Irvin G. Hoyt MD</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/12/59</u>	22c. NAME OF CEMETERY OR CREMATORIUM <u>WINCHESTER CEMT.</u>	22d. LOCATION (City, town, or county) <u>PRESTON R.D. MD.</u> (State) <u>—</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Weisbrot & Howell</u>		ADDRESS <u>EASTON, MD.</u>	24a. REC'D BY REGISTRAR DATE <u>DEC 16 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Trahan</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 1 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal and in any event with n/72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										Reg. Dist. No. 14112	
14141 CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY QUEEN ANNE'S MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND					b. COUNTY QUEEN ANNE'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural QUEENSTOWN		c. LENGTH OF STAY IN lb base		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural QUEENSTOWN		d. STREET ADDRESS /			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION											
3. NAME OF DECEASED (Type or print)		First WALTER	Middle LEE	Last WHITBY	4. DATE OF DEATH AUG 26 1959	Month AUG	Day 26	Year 1959			
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH MAY 18-1888	9. AGE (In years lost birthday) 71 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months 0		Days 0	Hours 0	Min. 0	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	10b. KIND OF BUSINESS OR INDUSTRY FARM TENANT		11. BIRTHPLACE (State or foreign country) MR CENTREVILLE MD	12. CITIZEN OF WHAT COUNTRY? USA					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARM TENANT		11. BIRTHPLACE (State or foreign country) MR CENTREVILLE MD		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME PERRY LEE WHITBY		14. MOTHER'S MAIDEN NAME IDA PINDER			Address Rural Queenstown Rd.						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 27-36-0376		17. INFORMANT SALLIE MAE JONES WHITBY	Address Rural Queenstown Rd.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Cerebral Hemorrhage			INTERVAL BETWEEN ONSET AND DEATH 15 min						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b) Hypertension Cardio Vascula DUE TO Arteriosclerosis			Years Years						
19. MEDICAL CERTIFICATION		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1045 Liberty		20f. (City or town) Centreville	(County) MD	(State) Maryland	DATE SIGNED 12-29-59		
21. I certify that I attended the deceased from Aug 17, 1959 to Dec 26, 1959 , that I last saw the deceased alive on Dec 26, 1959 , and that death occurred at 10 AM , from the causes and on the date stated above.					ADDRESS (Street, city or town, state) 1045 Liberty Centreville Md						
ACTUAL SIGNATURE C R Layton		M.D. C R Layton									
PHYSICIAN'S NAME (Type) C R Layton											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 29-59		22c. NAME OF CEMETERY OR CREMATORIUM Spring Hill		22d. LOCATION (City, town, or county) Gaston		(State) Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Young Brothers Funeral Bros Centreville Maryland		ADDRESS Young Brothers Funeral Bros Centreville Maryland			24a. REC'D BY REGISTRAR JAN 5 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kress				

STATE TO STATE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

14118

TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

1. PLACE OF DEATH a. COUNTY <i>Queen Anne's</i>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) b. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Queenstown</i>		c. LENGTH OF STAY IN 1b <i>60 yes.</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Queenstown</i>		d. COUNTY <i>Q. A.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Marion</i>		First <i>Wells</i>	Middle <i>Wilson</i>
Last <i>Yewell</i>		4. DATE OF DEATH <i>Dec. 5</i>	Month Year <i>1959</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 28, 1889</i>
9. AGE (In years last birthday) <i>70 yrs.</i>		10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Waterman</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>J.S.A.</i>	
13. FATHER'S NAME <i>William R. Yewell</i>		14. MOTHER'S MAIDEN NAME <i>Mary Tarr</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>220-32-876</i>	
17. INFORMANT <i>Mrs. Martha Yewell</i>		Address <i>Queenstown</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> DUE TO <i>420.1</i>			
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Irvin G. Hoyt</i>		DATE SIGNED <i>12/5/59</i>	
EXAMINER'S NAME (Type) <i>Irvin G. Hoyt</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Dec 8, 1959</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Chesterville</i>		22d. LOCATION (City, town, or county) <i>Chesterville Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. Edward Bailes Jr. Baileys Chesterville Md</i>		24a. REC'D BY REGISTRAR DATE <i>DEC 9 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>

如果MFC不能满足你的需求,请参阅MSDN或访问MSDN网站。